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3.1 Introduction

This section addresses Medicaid transportation services provided by the following provider specialties:

- Medical transportation by individual, agency, and commercial transportation providers
- Non-Medical Waiver transportation by individual and agency transportation providers

  Note: Non-Medical Waiver transportation services are covered for Enhanced Plan participants only.
- Ambulance transportation by non-hospital based ambulance providers

It also addresses the following processes:

- Electronic and paper claim billing
- Claims payment
- Prior authorization procedures
- Reconsideration requests and the appeals process

3.1.1 Non-Emergent Transportation (NET)

Non-Emergent Transportation (NET) is a ride provided so that a Medicaid client **with no other transportation resources** can receive Medicaid covered services.

NET does **not** include transportation provided on an emergency basis, such as ambulance trips to the emergency room in life threatening situations.

Only the least expensive, most appropriate means of transportation will be authorized. Other necessary transportation-related expenses may be authorized, such as meals (**only** if an overnight stay is required for travel), lodging, and medically necessary attendants for a Medicaid client to receive covered medical care or treatment. The Department will not pay for transportation, lodging, or meals when those services are available and provided at no cost by family, friends, or organizations such as Red Cross, Easter Seal Society, Cancer Society, fraternal and church organizations, Ronald McDonald Houses, and other private or social agencies.

Freedom of choice: Clients are allowed Freedom of Choice to seek care from the Medicaid provider of their choice. However, transportation miles will not be authorized beyond the round trip distance to the closest and most appropriate provider.

Refer to the IDAPA Medical Assistance Rules governing transportation and Medicaid covered services for further information. A copy of the current Transportation rules can be viewed on the State of Idaho Web site at: **www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf**, Sections 150 through 153.

A paper copy can also be obtained by contacting the Administrative Procedures office for the State of Idaho at (208) 334-5552 during normal business hours.

Note: Non-Emergent transportation services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.1.2 Client Eligibility

Transportation providers **must** ensure that the Medicaid clients they are transporting are eligible for Medicaid services **and** that the medical provider to whom the client is transported is a participating Idaho Medicaid provider.

See **Section 1.3.3, Verifying Client Eligibility**, for more information on how to verify eligibility.

3.1.3 Important Billing Instructions

3.1.4 Dates of Service

Dates of service must be within the Sunday through Saturday calendar week on a single detail line on the claim. The calendar week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. on Saturday. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one claim detail line.

Example: A provider transports a client everyday from Friday the 10th to Tuesday the 14th. Enter the date of service Friday the 10th to Saturday the 11th on the first detail line; enter the date of service Sunday the 12th to Tuesday the 14th on the second detail line.

Example: A provider transports a client on the 10th, 14th, and 16th. Enter each date on a separate detail line.

3.1.5 Payment

Medicaid Transportation providers will be reimbursed at the current rate established by the Department or the actual cost of the service, whichever is less.

3.1.6 Long Term Care Nursing Facilities

Medicaid does not pay for local transportation to Medicaid covered services rendered to clients who reside in a nursing home or intermediate care facility for the mentally retarded (ICF/MR). These transportation services are the responsibility of the facility. Medicaid may pay for necessary transportation to Medicaid covered services for mileage over 50 miles round trip for residents in long-term care facilities. In this case, the facility must be enrolled as a Medicaid "agency" transportation provider or they must use another Idaho Medicaid transportation provider. This transportation must be prior authorized.

3.1.7 Prior Authorization (PA)

Most transportation services require prior authorization (PA), which is authorization by the Department (or its designee) **before** the transportation occurs. Claims will not be paid unless the necessary PA was obtained **prior to** the transport. Refer to the appropriate procedure codes in **Sections 3.2.5, 3.3.4, and 3.4.5**, for details on services that do and do not require prior authorization.

Non-Medical Waiver transportation services for Developmental Disabilities, Aged and Disabled, and Traumatic Brain Injury require prior authorization. In addition, the participant must be enrolled in the Medicaid Enhanced benefitPlan. See **Section 3.5, Non-Medical Waiver Transportation Services**, for further information.

FORM AVAILABLE: the Transportation Request form and instructions are included in the Forms Appendix of this handbook.

Providers may also contact the MT for a paper or electronic copy of a blank request form.

See **Section 3.6.5, Ambulance Service Prior Authorization**, for information and procedures regarding non-hospital based ambulance authorizations.

3.1.8 Obtaining Prior Authorization

Follow these procedures to request a prior authorization for non-emergent transportation:

Make the request a minimum 24-hours before any scheduled appointment time. Allow for weekends and State holidays.

Identify the Medicaid covered service.

Calculate one-way miles and cost per unit prior to the request.

Use the Department's standardized transport request form which is found in the *Forms Appendix* of this provider handbook.

After a request for PA has been submitted to the Department's authorizing agent or designee, the Department will initiate a *Notice of Decision for Medical Benefits* to the client and the transportation provider indicating which procedures are authorized or denied. The procedure codes authorized on the notice must match the procedures codes billed on the claim form. The prior authorization number is **required** in box 23 of the CMS-1500 claim form or in the prior authorization field of an electronic claim.

See **Section 2.3.2** for more information on electronically billing services that require prior authorization.

When billing electronically, more than one prior authorization number is allowed on a claim. Prior authorization numbers can be entered at both the header and detail level. When billing services on a paper claim form, only one prior authorization number can be billed per claim.

To submit a prior authorization request:

By Mail:

Idaho Medicaid
Non-Emergent Transportation
P.O. Box 83720
Boise, ID 83720-0036

By Phone or FAX:

For Developmental Disability (DD) and Mental Health (MH) related requests contact **Dori Boyle**:

	Phone	**FAX**
Within the Boise calling area:	287-1172	334-4979
Outside of the Boise area:	(800) 296-0509 x 1172	(800) 296-0513

For all other non-emergent medical and out-of-state transportation requests contact **Sara Hunt:**

	Phone	**FAX**
Within the Boise calling area:	287-1173	334-4979
Outside of the Boise area:	(800) 296-0509 x 1173	(800) 296-0513

3.1.9 Requests for Reconsideration

Providers may request a reconsideration of a prior authorization (PA) decision made by the Department, by following these steps:

Step 1 Carefully examine the *Notice of Decision for Medical Benefits* to ensure that the service(s) and requested procedure code was actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider disagrees with the Department's decision, the next step is to submit a written *Request for Reconsideration* using the second page of the notice.

Step 2 Complete a written *Request for Reconsideration*, on the second page of the notice. Include any **additional** extenuating circumstances and **specific** information that will assist the authorizing agent in the reconsideration review. Attach a copy (front and back) of the *Notice of Decision for Medical Benefits.*

Step 3 Submit the written request directly to MT within 28 calendar days of the mailing date on the *Notice of Decision for Medical Benefits*. MT will review the additional information and return a second *Notice of Decision for Medical Benefits* to the requestor within 5 working days of receipt of the provider's *Request for Reconsideration*. If the **reconsidered** decision is still contested, the provider may then submit a written request for a contested case hearing. Medicaid consumers may request a fair hearing.

Step 4 Maintain copies (front and back) of all documents in your records for a period of five years.

3.1.10 Request for Hearing

Step 1 Prepare a written request for a hearing which must include:

- a copy of the *Notice of Decision for Medical Benefits* on which the provider requested the reconsideration
- a copy of the Reconsideration letter from MT which upheld the denial
- copies of any additional supporting documentation which should be considered at a hearing

Step 2 Mail or fax the information to:

Idaho Department of Health and Welfare
Hearings – Medicaid Transportation
P.O. Box 83720
Boise, ID 83720-0036

FAX: (208) 332-7347

MT will submit all documentation to the hearing officer who will schedule a hearing

Contact MT with any questions about the *Notice of Decision for Medical Benefits,* the reconsideration decision, or the appeal process.

3.2 Individual Medical Transportation Providers

3.2.1 Definition from Provider Agreement

(1.6) INDIVIDUAL TRANSPORTATION PROVIDER: Shall mean any individual who does not meet the definition of a Commercial *(or agency)* Transportation Provider and provides only transportation services or incidental services to a Medicaid client.

Individual providers may be the Medicaid client, a family member, guardian, friend, or other volunteer driver.

Note: Individual Medical Transportation services are not covered for **CHIP-B** participants.

Refer to the **CHIP--B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.2.2 Transportation Related Services

An **attendant** is an additional individual (other than a driver) who accompanies the client to medical services if deemed necessary due to the client's age or other mental/physical conditions. Attendant salary is never paid to a client's spouse or the parent of a minor child.

In special circumstances, MT may authorize meals and lodging when an overnight stay is required. Only the most appropriate, least expensive lodging will be authorized. Refer to IDAPA Rules governing non-emergent transportation. Meals and lodging are reimbursed at the rate established by Idaho Medicaid, or the actual cost, whichever is less, and only when an overnight stay is authorized. The meals and lodging for one attendant may be authorized if the client is a child or an adult whose physical or mental condition requires an attendant.

If meal preparation facilities such as a microwave oven are available in the authorized lodging facility, meals will not be authorized. Every effort is made to arrange for necessary lodging with cooking or microwave accommodations. Lodging and meals will not be authorized if the client and/or attendant stay in a private home that is not a lodging facility available to the general public. MT will authorize payment either directly to the lodging facility or to the client's individual transportation provider.

3.2.3 Place of Service Code

Enter the Place of Service Code **99** in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.2.4 Diagnosis Code

Enter the ICD-9-CM diagnosis code **7999** (Other Unknown), in field 21 on the CMS-1500 claim form or the appropriate field for electronic billing.

3.2.5 Individual Transportation Provider Billing Codes

All claims must use the following five-digit codes when billing for non-emergency transportation, meals, and lodging services. Descriptions of the code and prior authorization requirements are also indicated.

Service	Procedure Code	PA Required	Description
Airline travel	A0140	Yes	Non-emergency transportation and air travel (private or commercial) Intra- or interstate. One unit = 1 airline ticket
Attendant salary	T2001	Yes	Non-emergency transportation; patient attendant/escort (salary). Spouse or parent of a minor child cannot be paid as attendant. One unit = 15 minutes
Bus *pass* – city bus - fixed route within the city limits	T2004	Yes	Non-emergency transport; commercial carrier, multi-pass (bus pass). Usually valid for one calendar month (or more) One unit = 1 city bus pass
Car rental	T2003	Yes	Non-emergency transportation; encounter/trip (Car rental). One unit = 1 rental car
Lodging for client	A0180	Yes	Non-emergency transportation, ancillary; Lodging – client . One unit = 1 days lodging
Lodging for attendant	A0200	Yes	Non-emergency transportation, ancillary: lodging – attendant/escort. One unit = 1 days lodging
Meals for client	A0190	Yes	Non-emergency transportation, ancillary: meals – recipient. When travel requires an overnight stay. One unit = 1 days total meal charges
Meals for attendant	A0210	Yes	Non-emergency transportation, ancillary: meals – attendant/escort. When travel requires an overnight stay. One unit = 1 days total meal charges
Mileage: 21 miles or more	S0215 **TF** modifier	Yes	Non-emergency transportation; mileage, per mile (individual – 21 miles and over). One unit = 1 mile Code must be reported with modifier **TF**
Mileage: 0 – 20 miles	S0215	No	Non-emergency transportation; mileage, per mile (individual – under 20 miles). One unit = 1 mile
Parking fees and tolls	A0170	No	Transportation, ancillary: parking fees, tolls, other. Attach receipt to claim form. One unit = 1 days total fees
Taxi - intra city	A0100	Yes	Non-emergency transportation; taxi (city taxi). One unit = 1 one-way trip

3.3 Commercial Transportation Providers

3.3.1 Definition from Provider Agreement

(1.3) COMMERCIAL TRANSPORTATION PROVIDER: Shall mean an entity in the business of transportation that is organized to provide, that publicly holds itself out to provide, and that actually provides personal transportation services to the general public. By holding itself out to the general public, the PROVIDER vigorously and diligently solicits riders from the general populace. By actually providing services to the general public, the Provider ridership includes substantial numbers of persons whose travel is funded by a source other than Medicaid.

Commercial providers may include:

- taxis
- intra-city or inter-city buses or vans
- intrastate or interstate buses (such as Greyhound) or vans
- airlines (travel agencies)
- car rental agencies
- lodging facilities

Reimbursement is at the rate established by Idaho Medicaid, or the actual cost, whichever is less.

All transportation services provided by commercial carriers require prior authorization by Medicaid Transportation (MT).

Note: Commercial Transportation services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.3.2 Place of Service Code

Enter the Place of Service code **99** in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.3.3 Diagnosis Code

Enter the ICD-9-CM diagnosis code **7999** (Other Unknown) in field 21 on the CMS-1500 claim form or the appropriate field for electronic billing.

3.3.4 Commercial Transportation Provider Billing Codes

Idaho Medicaid uses HCPCS procedure codes. All claims must include the following five-digit codes when billing for non-emergency transportation and lodging services. Providers and clients will receive a prior authorization notice, which will identify the procedure codes that have been approved and are to be used for billing.

DEFINITIONS:

Bus: a commercial vehicle with a capacity of 16 or more passengers (including the driver) and requires the driver to have a Certified Drivers License (CDL) and any necessary endorsements.

Van: a commercial vehicle with a capacity up to 15 passengers (including the driver).

Service	Code	PA	Description
Airline travel	A0140	Yes	Non-emergency transportation and air travel (private or commercial), intra- or interstate. Attach receipt to claim form. One unit = 1 airline ticket
Attendant salary	T2001	Yes	Non-emergency transportation; attendant/escort (salary) Spouse or parent of a minor child cannot be paid as attendants. One unit = 15 minutes
Bus or van travel	A0110	Yes	Non-emergency transportation and bus, intra or interstate carrier. Also used for demand response, door-to-door, or curb-to-curb transportation provided by a commercial van or bus provider. One unit = 1 loaded vehicle mile
Bus *pass* - city bus fixed route within the city limits	T2004	Yes	Non-emergency transport; commercial carrier, multi-pass (bus pass). Usually valid for one calendar month (or more). One unit = 1 city bus pass
Car rental	T2003	Yes	Non-emergency transportation; encounter/trip (Car rental). Attach receipt to claim form. One unit = 1 rental car
Lodging client	A0180	Yes	Non-emergency transportation, ancillary; Lodging --- recipient. Attach receipt to the claim form. One unit = 1 days lodging
Lodging attendant	A0200	Yes	Non-emergency transportation, ancillary: lodging – attendant/escort. Attach receipt to the claim form. One unit = 1 days lodging
Meals for client	A0190	Yes	Non-emergency transportation, ancillary: meals – recipient. When travel requires an overnight stay. One unit = 1 days total meal charges
Meals for attendant	A0210	Yes	Non-emergency transportation, ancillary: meals – attendant/escort. When travel requires an overnight stay. One unit = 1 days total meal charges
Taxi intra-city	A0100	Yes	Non-emergency transportation; taxi (city taxi). Attach receipt to claim form. One unit = 1 one-way trip

3.4 Agency Transportation Providers

3.4.1 Definition from Provider Agreement

(1.1) AGENCY TRANSPORTATION PROVIDER: Shall mean any of the following:

(1.1.1) An entity whose employees or agents provide transportation services in addition to one or more other services to the same Medicaid client or ; or

(1.1.2) An entity whose employees or agents transport Medicaid clients to or from another Medicaid service in which the entity has ownership or control; or

(1.1.3) An entity whose employees or agents transport Medicaid clients pursuant to an arrangement that is not an arm's-length transaction.

All transportation services for a client that are over 20 total loaded miles in one calendar day require prior authorization by the Medicaid Transportation (MT). See **Section 3.4.5, Agency Provider Procedure Codes**, for details on those services that do and do not require prior authorization.

Note: Agency Transportation services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.4.2 Transportation Related Expenses

Agency transportation providers do not supply meals or lodging and, therefore, cannot bill for these services.

3.4.3 Place of Service Code

Enter the Place of Service code **99** in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.4.4 Diagnosis Code

Enter the ICD-9-CM code **7999** (Other Unknown), for the diagnosis in field 21 on the CMS-1500 claim form or the appropriate field for electronic billing.

3.4.5 Agency Provider Procedure Codes

Service	Procedure Code	PA Required	Description (Notes)
Attendant salary	T2001	Yes	Non-emergency transportation; patient attendant/escort (salary) Spouse or parent of a minor child cannot be paid as attendants. One unit = 15 minutes
Bus *pass* city bus - fixed route within the city limits	T2004	Yes	Non-emergency transport; commercial carrier, multi-pass (bus pass). Usually valid for one calendar month (or more). One unit = 1 city bus pass
Mileage 21 miles or more	S0215 **TF** modifier	Yes	Non-emergency transportation; mileage, per mile. (Agency – 21 miles and over). One unit = 1 mile *Code must be reported with modifier ***TF***
Mileage - 0–20 miles	S0215	No	Non-emergency transportation; mileage, per mile. (Agency – under 20 miles). One unit = 1 mile

3.5 Non-Medical Waiver Transportation Services – Developmental Disabilities Waiver, Aged and Disabled Waiver, and Traumatic Brain Injury Waiver

3.5.1 Overview

Medicaid clients who qualify for Waiver Services may receive non-medical transportation services to gain access to community services, resources, and activities identified on the Plan of Care.

Waiver Services are offered to Medicaid clients under three programs: Developmental Disabilities (DD); Aged and Disabled (A&D); and Traumatic Brain Injury (TBI). This non-medical transportation service is offered in addition to medical transportation service and shall not replace it.

Clients will receive a prior authorization notice that will identify the procedure codes that have been approved and are to be used for billing. Prior authorizations for wavier transportation services are issued by the regional DHW offices.

Payment for Non-Medical Waiver transportation is reimbursed at the per-mile rate established by Idaho Medicaid and is limited to 1800 miles per calendar year. The vehicle's owner is responsible for all necessary insurance. An agency or individual transportation provider may provide waiver transportation services.

Note: Non-Medical Waiver transportation services are covered for Enhanced Plan participants only.

Note: Non-Medical Transportation services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.5.2 Codes for DD Waiver Services

3.5.2.1 Diagnosis Code for DD Waiver

Enter the ICD-9CM diagnosis code **7999**-Other Unknown, in field 21 on the CMS-1500 claim form or the appropriate field for electronic billing.

3.5.2.2 Place of Service Code for DD Waiver

Enter the Place of Service code **99** in field 24B on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

3.5.2.3 Prior Authorization for DD Waiver

Non-Medical Waiver transportation services for Developmentally Disabled (DD) require prior authorization by the Regional DHW office:

Region I	Coeur d'Alene, ID	(208) 769-1588
Region II	Lewiston, ID	(208) 799-3460
Region III	Caldwell, ID	(208) 459-0092 (Adult) (208) 465-8460 (Children)
Region IV	Boise, ID	(208) 334-0900

Region V	Twin Falls, ID	(208) 736-2182
Region VI	Pocatello, ID	(208) 234-7900
Region VII	Idaho Falls, ID	(208) 525-7223

3.5.2.4 Transportation Procedure Code for DD Waiver

Service	Code	Modifier	PA Required	Description (Notes)
Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization), with no vested interest (Non-Medical DD Transportation)	A0080	**U8**	Yes	• Use when a DD Transportation provider transports clients to DD Waiver services that are non-medical in nature. • Bill only one trip per detail line. • Requires modifier U8 to report services for the DD waiver. • Use modifier **76** in addition to modifier U8, when billing for additional trips on the same day. Use modifier **52** in addition to modifier U8, when billing a one-way trip. • Limited to 1800 miles per DD client, per calendar year. • Minimum age is 18. • One unit = 1 mile

3.5.3 Codes for A&D and TBI Waivers

3.5.3.1 Diagnosis Code for A&D and TBI Waivers

Enter the ICD-9-CM diagnosis code **7999** – *Other Unknown* in field 21 on the CMS-1500 claim form.

3.5.3.2 Place of Service Code for A&D and TBI Waivers

Enter the Place of Service code **99 - Community** in field 24B on the CMS 1500 claim form or in the appropriate field of the electronic claim form.

3.5.3.3 Prior Authorization for A&D and TBI Waivers

Prior authorization number must be included on the claim or the service will be denied.

Non-Medical Waiver transportation services for both Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) require prior authorization by the Regional DHW office:

Region I	Coeur d'Alene, ID	(208) 769-1567
Region II	Lewiston, ID	(208) 799-4430
Region III	Caldwell, ID	(208) 455-7150
Region IV	Boise, ID	(208) 334-0940
Region V	Twin Falls, ID	(800) 736-3024
Region VI	Pocatello, ID	(208) 239-6260
Region VII	Idaho Falls, ID	(208) 528-5750

3.5.3.4 Procedure Codes for A&D and TBI Waivers

Service	Code	Modifier	PA Required	Description
Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization), with no vested interest (A&D non-medical transportation)	A0080	**U2**	Yes	A&D non-medical transportation, per mile as authorized by the RMS. One unit = 1 mile The maximum allowable units per year are 1800. • Requires modifier U2 to report services for the A&D waiver
Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization), with no vested interest (TBI non-medical transportation)	A0080	**U3**	Yes	TBI non-medical transportation, per mile as authorized by RMS. One unit = 1 mile The maximum allowable units per year are 1800. • Requires modifier U3 to report services for the TBI waiver

3.6 Ambulance (non-hospital based) Transportation Service Policy

3.6.1 Overview

Ambulance services are payable by Medicaid only if used in the event of a medical emergency or after prior authorization has been obtained from Medicaid Transportation (MT). Medicaid Transportation manages ambulance transportation services including prior authorization of non-emergency ambulance transportation and medical review of emergency ambulance claims. Ambulance service must be medically necessary, as determined by MT, in order to be paid by Medicaid.

Policy and billing information for hospital-based ambulance services can be found in the Hospital Guidelines, **section 3.10 Ambulance Service Policy** The hospital handbook is located at:
http://www2.state.id.us/dhw/medicaid/provhb/s3_hospital.pdf

Note: Non-Emergent Ambulance transportation services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.6.2 Definition of Emergency Services

Medical necessity is established when the client's condition is of such severity that use of any other mode of transport would endanger the client's life or health. An emergency exists when the severity of the medical situation is such that the usual prior authorization procedures are not possible because the client requires immediate medical attention. See **Section 3.7.5.3, Base Rate for Ambulances,** for a description of ambulance levels of care.

3.6.3 Definition of Non-emergency Service

Medicaid defines a non-emergency ambulance service as scheduled ambulance transport, which is medically necessary due to the medical condition of the client, when any other form of transportation will place the client's life or health in serious jeopardy. This includes inter-facility transfers, nursing home to hospital transfers, and transfers to the client's home from the hospital. All scheduled, non-emergency ambulance transports must be approved prior to the transport.

3.6.4 Licensing Requirements

Medicaid ambulance service providers must hold a current license issued by the Emergency Medical Services (EMS) Bureau and must comply with the rules governing EMS services. Ambulance services based outside the State of Idaho must hold a current license issued by that state's EMS licensing authority.

EMS Bureau Phone: (208) 334-4000
FAX: (208) 334-4015

3.6.5 Billing Information

Non-hospital based ambulance providers may bill electronically or on the CMS-1500 claim form. Forms are available from local form suppliers.

Required attachments include third party payer explanation of benefits for payments or denials.

3.6.5.1 Customary Fees

Ambulance service charges to Medicaid cannot exceed the provider's charges to the public for the same service (usual and customary fee). Reimbursement for non-hospital-based ambulance service is at the rate established by Idaho Medicaid.

Transportation of Nursing Home or Intermediate Care Facility/Mentally Retarded (ICF/MR) residents is the responsibility of the facility unless the medical condition of the client requires ambulance transport. All non-emergency ambulance transports must be prior authorized by MT.

3.6.5.2 Payment in Full

The Claimants Certification, (reverse side of the CMS claim form) signed on each claim submitted for payment, indicates the Medicaid payment for the charges on that claim will be accepted as payment in full for the services rendered. The client is not responsible for the unpaid balance remaining on covered services, and should not be billed.

3.6.5.3 Medicare Clients

If a client has Medicare coverage, the provider must first bill Medicare for services rendered. See **Section 2, Third Party Recovery**, for billing instructions.

3.6.5.4 Submitting Claims to EDS

Providers must document the PA number on the claim form and submit the claim to EDS for payment. When billing electronically, prior authorization numbers can be entered at either the header or the detail level. When billing on paper, the provider can only use one prior authorization number, at the header level, for each claim. The provider's claim must match the authorized services on the *Notice of Decision for Medical Benefits* or the claim will be denied. Contact the MT with questions pertaining to the review of ambulance claims.

3.6.6 Covered Services

3.6.6.1 Air Ambulance

Medicaid covers air ambulance services when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the client to the nearest appropriate facility and urgent medical care is needed.
- The client's condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by MT in advance except in emergency situations. Non-hospital-based air ambulance services must be billed on the CMS-1500, using HCPCS codes. Only air ambulances that are owned or leased, and operated by a hospital are designated by Idaho Medicaid as

Idaho Medicaid Provider Handbooks are available on the Internet at:

www2.state.id.us/dhw/medicaid/provhb/index.htm

hospital-based. The services must be billed on a UB92 claim form using revenue codes from the *Idaho Medicaid Provider Handbook* for hospitals.

3.6.6.2 Ground Ambulance

Non hospital-based, ground ambulance services must be billed on a CMS 1500 claim form using HCPCS procedure codes. Only ground ambulances that are owned or leased, and operated by a hospital are designated by Idaho Medicaid as hospital-based. Those services must be billed on a UB92 using revenue codes from the *Idaho Medicaid Provider Handbook* for hospitals.

3.6.6.3 Base Rate for Ambulances

Levels of Service

Providers may report one of the following levels of service for transporting Medicaid clients. Providers may also request payment for *treat and release* or *respond and evaluate* if the patient is not transported. The three levels of service are:

- Basic Life Support (BLS) (emergency and non-emergency)
- Advanced Life Support (ALS) I (emergency and non-emergency)
- Advanced Life Support (ALS) II (emergency and non-emergency)

When reviewing and authorizing a particular level of service the MTU must consider if:

- the requested level of service is equal to or below the level of EMS certification of the personnel providing care in the patient compartment of the vehicle
- the certification level of the provider is documented on the patient care record
- the type of care provided corresponds with the level of service requested

Each level of service corresponds with the Idaho Administrative Code acts and duties allowed for the pre-hospital care providers, as per IDAPA 16.02.03.325. The following may be used as a guideline in determining the level of service.

Separate fees are not allowed for components of BLS or ALS care, such as starting IVs and administering oxygen. This includes all non-disposable equipment used in the treatment such as backboards, scoop stretchers, and cervical collars. Disposable (consumable) equipment and medications are included in the base rate payment for ground ambulance services and may not be billed separately.

Basic Life Support (BLS)
BLS includes all acts and duties that may be performed by a certified Emergency Medical Technician - Basic (EMT-B). The care may be provided by personnel with a *higher* level of certification (e.g., Advanced EMT-A, EMT-Paramedic, Registered Nurse), but if the care provided falls within the scope of practice for the EMT-B, the level of reimbursement is BLS. Common examples include patient assessment, bleeding control, spinal immobilization, the use of oxygen and splints. For a complete list of the skills

and duties allowed for an EMT-B, refer to the Board of Medicine Rules for EMS Personnel.

Advanced Life Support (ALS) Level I (emergency and non-emergency)
ALS Level I emergency and non-emergency includes the transportation by ambulance and the provision of at least one medically necessary ALS intervention or treatment. An ALS intervention is a procedure that is beyond the scope of practice of an EMT-B. Common examples include peripheral venous puncture, electrocardiogram (EKG) rhythm interpretation, and administration of various medications used in medical, respiratory or behavioral emergencies. For a complete list of the skills and duties allowed, refer to the Board of Medicine Rules for EMS Personnel.

Advanced Life Support (ALS) Level II
ALS Level II includes the transportation by ambulance and the medically necessary administration of at least three separate administrations of one or more medications by intravenous push/bolus or continuous infusion or one of the following medically necessary treatments:

- manual defibrillation/cardioversion
- endotracheal intubation
- central venous line
- cardiac pacing
- chest decompression
- surgical airway
- intraosseous line

3.6.6.4 Waiting Time and Extra Attendants

Waiting time and extra attendants are not paid unless medically necessary and authorized by MT. Waiting time must be physician-ordered.

3.6.6.5 Multiple Runs in One Day

When the ambulance transports a client, returns to the base station, and transports the client a second time on the same date, two base rate payments and loaded mileage are allowed. Use modifier 76 on the second procedure code to prevent denials for duplicate claims.

When the ambulance transports a client, the client is transferred to another facility, and the ambulance does not return to the base station, one base rate, waiting time, and loaded mileage are allowed.

3.6.6.6 Round Trip

Medicaid allows round-trip charges when a hospitalized client is transported to another hospital to obtain specialized services not available at the original hospital, and the referral hospital is the nearest one that offers special services.

Medicaid places restrictions on round-trip charges, depending on whether the ambulance returns to the base station between trips. When the ambulance does not return to base station, bill for one base rate, round-trip loaded miles, and waiting time (limited to one and one-half hours). When the

ambulance does not wait but returns to the base station between trips, bill for two base rates and loaded round-trip mileage.

3.6.6.7 Physician in Attendance

When a physician is in attendance, the documentation should justify the necessity and specialty type of the physician. The physician is responsible for the billing of his/her services.

3.6.6.8 Nursing Home Residents

Ambulance services are covered only in an emergency situation or when prior authorized by MT. Payment for any non-covered non-emergency service is the responsibility of the facility and ambulance providers may not bill Medicaid.

3.6.6.9 Trips to Physician's Office

Ambulance service from a client's home to a physician's office is not covered unless prior authorized by MT.

3.6.6.10 Treat and Release

A **treat and release** payment may be authorized if the client is treated at the scene and not transported. Disposable supplies are included in the treat and release payment. Treat and release may be requested at the BLS or ALS level, depending on the treatment provided. See **Section 3.7.5.3, Base Rates for Ambulances**, for details on determining the appropriate level of service.

MT may downgrade a claim to a treat and release payment if the client was transported but the transport is determined to be not medically necessary. No mileage will be paid.

3.6.6.11 Respond and Evaluate

A **respond and evaluate** payment may be authorized if the ambulance responds to the scene and evaluates the client, but treatment or transport is not necessary.

MT may downgrade a claim to a respond and evaluate payment if the client was transported, but the transport is determined to be not medically necessary. No mileage, supplies, nor other services will be paid in addition to payment for respond and evaluate.

3.6.6.12 Deceased Clients

Ambulance service for deceased clients is covered when documented in the run sheet as follows:

- If the client was pronounced dead after the ambulance was called but before pickup, a base rate will be allowed.
- If the client was pronounced dead while in route to or upon arrival at the hospital, a base rate and mileage will be allowed.
- If the client was pronounced dead by an authorized person before the ambulance was called, no payment will be made.

Contact Medicaid Transportation, Ambulance Review

(208) 287-1155 or
(800) 362-7648

FAX
(208) 334-5242
(800) 359-2236

3.6.7 Ambulance Service Prior Authorization

3.6.7.1 Overview

All provider claims for ambulance services must be reviewed and authorized as medically necessary and appropriate by MT before Medicaid will reimburse the ambulance provider. Medicaid claims for ambulance services must include a PA number from MT when submitted to EDS for payment.

3.6.7.2 Non-emergency Ambulance Transportation

If non-emergency, scheduled travel by ambulance is medically necessary, prior authorization (PA) is required before the transport occurs. For services that require prior authorization, the prior authorization number must be included on the claim or the claim will be denied. Prior authorization is done by contacting the Medicaid Transportation (MT) twenty-four (24) hours before the scheduled trip.

Examples of non-emergent ambulance transport may be from a hospital to a rehabilitation center or nursing home, or a bed-ridden client traveling from home to a scheduled medical appointment. A client's life and health must be in jeopardy if transported by any means other than ambulance to a scheduled destination.

3.6.7.3 Emergency Transportation

Notify MT by fax or mail of all emergency transports by submitting a claim form, patient care record, and explanation of benefits from a third party payer, if applicable. See **Section 3.7.9, Requests for Retrospective Review/Authorization,** for more information.

3.6.8 Ambulance Procedure Codes

All ambulance services by a *non hospital-based ambulance* should be billed on a CMS-1500 claim form or submitted electronically using the following HCPCS codes. It is not necessary to attach the run sheet to the claim. Payment for ambulance transport is for a one-way trip in which the client is in the patient compartment of the vehicle, except when a round trip is authorized by MT.

3.6.8.1 Ambulance Service Procedure Codes

Description	Code	Notes
Ground Ambulance		
Ambulance Waiting Time (ALS or BLS), one-half (1/2) hour increments	A0420	One unit = one-half hour. Do not count the first half-hour, which is included in the base rate. Must be physician ordered.
Extra Ambulance Attendant, ground (ALS or BLS) or Air (fixed or rotary winged) Requires medical review	A0424	Attendant must be in the patient compartment of the ambulance and actively treating or attending the patient. One unit = total charges for one extra attendant.
Ground Mileage, per statute mile	A0425	
Ambulance Service, Advanced Life Support, non-emergency transport, level 1 (ALS 1)	A0426	
Ambulance Service, Advanced Life Support, emergency transport, level 1 (ALS 1-emergency)	A0427	
Ambulance Service, Basic Life Support, non-emergency transport (BLS)	A0428	
Ambulance Service, Basic Life Support, emergency transport (BLS –emergency)	A0429	
Advanced Life Support , Level 2 (ALS 2)	A0433	
Respond and Evaluate, no other services (all levels)	T2006	Treat and Release (ambulance response and treatment, no transport)
Response and Treatment, Basic Life Support	T2006	
Response and Treatment, Advanced Life Support	T2006	
Air Ambulance		
Ambulance Service, conventional air services, transport, one way (fixed wing)	A0430	Base rate
Ambulance Service, conventional air services, transport, one way (rotary wing)	A0431	Base rate
Fixed wing air mileage, per statute mile	A0435	
Rotary wing air mileage, per statute mile	A0436	

3.6.9 Requests for Retrospective Review/Authorization

To obtain a retrospective authorization for emergency services and transportation, FAX or mail a copy of the completed claim form and patient care record to MT. Attach a copy of the third party Explanation of Benefits (EOB) if applicable.

Upon receipt of the completed claim information:

1. The level of service requested by the provider is evaluated. The level of service billed cannot exceed the level of EMS certification unless the personnel providing care in the patient compartment have a higher level of certification than the ambulance license.
2. The claim is evaluated for appropriate mileage. Disposable supplies are included in the base rate payment and may not be billed separately.
3. Any potential denial or downgrade of the requested service is referred to an on-call emergency medicine physician for review prior to the denial or downgrade.

An approved or denied decision is submitted to EDS and a *Notice of Decision for Medical Benefits* is generated to the client and the ambulance provider. The *Notice of Decision* will include a Prior Authorization (PA) number procedure codes, dates of service, and number of units necessary for billing. Questions regarding *Notice of Decision for Medical Benefits* should be directed to MT at (208) 287-1155 or (800) 362-7648.

3.6.10 Requests for Reconsideration (Appeals)

Providers may appeal a prior authorization (PA) decision made by the Department or its designee, by following these steps:

Step 1 Carefully examine the *Notice of Decision for Medical Benefits* to ensure that the service(s) and requested procedure code was actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider determines that an inappropriate denial of service has occurred, the next step is to submit a written *Request for Reconsideration*.

Step 2 Prepare a written *Request for Reconsideration*, which includes any **additional** extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review.

Step 3 Submit the written request directly to MT within 30 days of the date on the *Notice of Decision for Medical Benefits*. MT will return a second *Notice of Decision for Medical Benefits* to the requestor within 30 days of receipt of the provider's *Request for Reconsideration*. If the **reconsidered** decision is still contested by the provider, the provider may then submit a written request for an appeal of the reconsideration review decision directly to the Department of Health and Welfare.

A written appeal must be received within **Twenty-eight (28) Days** from the date on of the MT reconsideration review decision, follow the steps below. Providers may fax all documentation but the fax must be followed with copies of original documents in the mail.

Step 1 Prepare a written request for an appeal that includes:

- a copy of the *Notice of Decision for Medical Benefits* from MT
- a copy of the *Request for Reconsideration* from the provider
- a copy of the second *Notice of Decision for Medical Benefits* from MT showing that the request for reconsideration was performed
- an explanation of why the reconsideration remains contested by the provider
- copies of all supporting documentation

Step 2 Mail the information to:

Hearings Coordinator
Idaho Department of Health and Welfare
Administrative Procedures Section
P.O. Box 83720
Boise, ID 83720-0036

FAX: (208) 332-7347

Contact MT with any questions about the Notice of Decision for Medical Benefits, the reconsideration decision, or the appeal process.

Contact Medicaid Transportation, Ambulance Review at:

(208) 287-1155 or
(800) 362-7648

FAX:
(208) 334-5242 or
(800) 359-2236

3.7 Claim Billing

3.7.1 Which Claim Form to Use

All claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.7.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.7.2.1 Guidelines for Electronic Professional Claims

See **Section 2 , General Billing Information,** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim. For services that require prior authorization, the prior authorization number must be included on the claim or the services will be denied.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Ambulance services
Idaho requires the following information when submitting an electronic HIPAA 837 Professional claim for ambulance services.

- Transport Code
- Transport Reason Code
- Transport Distance
- Condition Code
- Round Trip Purpose when the transport code is equal to X for round trip.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.7.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2004 is entered as 07042004

3.7.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.7.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.7.4 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Field	Field Name	Use	Directions
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, where the injury occurred and if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MT.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2004 becomes 11242004 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the corresponding diagnosis code entered in field 21.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.

Field	Field Name	Use	Directions
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.7.5 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION